This form may be completed online, printed and mailed to the address listed below.

11/02

NURSE AIDE **ORAL** EXAMINATION REGISTRATION FORM

Office Use Only

EXAMINATION SITE: _____ EXAMINATION DATE: _____

	Name & Address (First, M. Initial, Last)	SS #:	Date of Birth	Date of Hire	Course Completion Date		(Leave Blank)	**SCORE**
1.	_____	_____	_____	_____	_____	1.	_____	_____

(address)_____

I certify that the individual listed above completed at least a 75-hour training program at this facility under my responsibility.

_____ _____ _____ _____

Signature of the Program Coordinator R.N. License # Facility Name & City Date

Facility Telephone #: _____

REGISTRATION FOR INDIVIDUAL NOT TRAINED AT THIS FACILITY OR AN INTERSTATE ENDORSEMENT

	Name & Address (First, M. Initial, Last)	SS #:	Date of Birth		(Leave Blank)	**SCORE**
1.	_____	_____	_____	1.	_____	_____

(address) _____

Facility Telephone #: _____

I have verified that the above applicant has completed an approved program that meets Federal and State of Nebraska training requirements and is eligible to take this examination.
**** A copy of the letter from our office indicating this test is required must be attached for the applicant.**

_____ _____ _____ _____

Signature of the Director of Nurses or Prog. Coord. R.N. License # Facility Name & City Date

Please return this form to: **Department of Health & Human Services Regulation and Licensure, Credentialing Division, PO Box 94986, Lincoln, NE 68509-4986 or fax 402-471-1066**